

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029053

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 68

FILED AUG 12 1963

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		c. CITY OR TOWN Kansas City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION U.S. Highway # 24 (3 Mi. West of Lexington)		d. STREET ADDRESS (If outside, give location) 414 So. Cypress	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES WILLIAM SUTTON		4. DATE OF DEATH Month Day Year July 30 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. AGE (last birthday) August 5 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Student	11. BIRTHPLACE (City and state or country) Independence, Mo.
13a. FATHER'S NAME Ralph Edward Sutton		13b. MOTHER'S MAIDEN NAME Rose Della Duett	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No No		17. INFORMANT Address K.C., Mo. Ralph E. Sutton 414 So. Cypress	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe crushing chest injury Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) auto accident DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Auto accident - victim allegedly fell from & crushed by the auto in which he was riding.	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year July 30, 1963	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) As in 1(c) above.	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 7-30-63 to 32 hrs and last saw her alive on P.O.A., Memorial Hosp., Lexington, Mo., 4:5 pm on 7-30-63 on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William C. Labbe, MD.		22b. ADDRESS Medical Clinic Lexington, Missouri	22c. DATE SIGNED 8-1-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-2-63	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Blackman Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 8-1-63	26. REGISTRAR'S SIGNATURE M. E. ...

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

*Embalmed Harold L. Walker
m 5-1-63*